MAIL TO:
OFFICE OF WORKERS' COMPENSATION
POST OFFICE BOX 94040
BATON ROUGE, LA 70804-9040
(225) 342-7565 TOLL FREE (800) 201-3457

1. Social Security No. _____-_____-_____

2. Date of Injury/Illness _____-_____-_____

NOTICE OF PAYMENT

This form is to be completed by the Employer/Insurer and sent to the injured employee with the first check or within 10 days of suspension/modification and/or change to SEB. A copy must be sent to the Office of Workers' Compensation Administration within 10 days of the effective date.

3. Purpose of Form (check one):
☐ Payment ☐ Modification ☐ Suspension ☐ Change to SEB

4. Employee Name _____ 5. _____ - _____ - _____
Effective Date

6. Part(s) of Body Injured _____

7. Nature of Injury _____

8. Compensation is paid as follows:

☐ A. Weekly payments of $ _____ based on an average weekly wage of $ _____ have begun.

☐ B. Payments re-started at $ _____ per week.

☐ C. Payments reduced by $ _____ due to:
☐ Social Security Benefits ☐ Other Workers' Compensation Benefits
☐ Employer Disability Benefits ☐ Unemployment Insurance Benefits
☐ Third Party Recovery ☐ Refused Rehabilitation
☐ Other: _____

☐ D. Permanent Partial Benefits of $ _____ will be paid for _____ weeks.

☐ E. Supplemental Earnings Benefits of $ _____ will begin _____ The exact amount received weekly may vary.

☐ F. Death Benefits have begun in the amount of $_____ per week, representing _____% of wages.

☐ G. Payment suspended due to employee failing to cooperate.

☐ H. Other reasons or explanations _____

9. Submitted by:

Preparer's Name: _____ Employee Name: _____

Employer/Insurer: _____ Employer: _____

Address: _____ Address: _____

_____ _____

Phone: ( ) _____ Phone : ( ) _____

Employer/Insurer NCCI Number: _____

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